Role of

Department of Insurance

Medicaid Prompt Payment Compliance

Facilitating Complaints

Helping to Improve Medicaid Managed Care

Who we are

What we do

What we need from you

Brian K. Staples—Health Care Data Administrator

Who are we----What do we do--What we need from you

- Medicaid Prompt Payment Compliance
  - Consumer Protection Division
  - Kentucky Department of Insurance
  - Public Protection & Regulation Cabinet
  - Established April 15, 2013
- Facilitate Medicaid MCO complaints regarding insurance statutes
- Properly completed complaint forms with all supporting documentation

Kentucky Revised Statutes
Kentucky Administrative Regulations

- KRS 304.17A-270
- KRS 304.17A-700
- KRS 304.17A-702
- KRS 304.17A-704
- KRS 304.17A-705
- KRS 304.17A-706
- KRS 304.17A-708
- KRS 304.17A-710
- KRS 304.17A-712
- KRS 304.17A-714
- KRS 304.17A-716
- KRS 304.17A-718
- KRS 304.17A-720
- KRS 304.17A-722
- KRS 304.17A-724
- KRS 304.17A-728
- KRS 304.17A-730
- 806 KAR 17:310

Any willing Provider

- KRS 304.17A-270
  - "Any willing provider" statute
    - Insurer must accept any provider who provides services within the geographic region of the network where the Provider meets the credentialing standards of the insurer and is willing to accept the terms of the insurer's contract

KRS 304.17A-700 thru 730

- "Prompt Payment" statutes
- Definitions
- Payment of clean claims
- Acknowledgement of receipt of claims & identification of missing or incorrect information on billing instruments
- Contested and denied claims
- Claim refunds, overpayments & dispute resolution
- Payment of interest on claims

KRS 304.17A-702

Requires MCO to pay, deny, or contest **clean claims** within thirty (30) days of acknowledgement of **receipt of claim.**

CLEAN CLAIM

Properly completed billing instrument, paper or electronic including the required health claim attachments, submitted on the proper and applicable form.

KRS 304.17A-704

- Requires MCO to acknowledge receipt of an **original or corrected claim** within:
  - 48 hours if electronically submitted
  - 20 days if claim submitted by mail

KRS 304.17A-704

- Requires MCO—at time of acknowledgement to notify the provider, its billing agent or designee that submitted the **claim**:
  - All information missing from the billing instrument or incorrect information on the billing instrument
  - Any errors in the billing instrument
  - Any other circumstances which preclude it from being a **clean claim**

KRS 304.17A-706
Contested Claims

A MCO may contest a **clean claim** only in the following instances:

- The MCO believes there are coordination of benefits or another insurer primarily responsible for the claim
- MCO will conduct retrospective review
- MCO has info claim was submitted fraudently
- Premium not paid

KRS 304.17A-708—Resolution of payment errors; retroactive denial of claims

- MCO shall not require a provider to appeal payment errors where MCO has not paid the claim according to the contracted rate.
  - Miscalculations made by MCO corrected & paid within 30 days of receipt of documentation verifying the error.
- MCO not required to correct error if provider's request is filed more than 24 months after payment received.

304.17A-712 Claim refunds and overpayments.

If an insurer determines that payment was made for services rendered to an individual who was not eligible for coverage or that payment was made for services not covered by a covered person's health benefit plan, the insurer shall give written notice to the provider and:

(1) Request a refund from the provider; or

(2) Make a recoupment of the overpayment from the provider in accordance with KRS 304.17A-714.

304.17A-714 Collection of claim overpayments -- Dispute resolution.

(1) Except for overpayments which are a result of an error in the payment rate or method, an insurer that determines that a provider was overpaid shall, within twenty-four (24) months from the date that the insurer paid the claim, provide written or electronic notice to the provider of the amount of the overpayment, the covered person's name, patient identification number, date of service to which the overpayment applies, insurer reference number for the claim, and the basis for determining that an overpayment exists. Electronic notice includes e-mail or facsimile where the provider agreed in advance in writing to receive such notices. The insurer shall either:

(a) Request a refund from the provider; or

(b) Indicate on the notice that, within thirty (30) calendar days from the postmark date or electronic delivery date of the insurer's notice, if the insurer does not receive a notice of provider dispute in accordance with subsection (2) of this section, the amount of the overpayment will be recouped from future payments.

304.17A-714 Collection of claim overpayments -- Dispute resolution.

(2) If a provider disagrees with the amount of the overpayment, the provider shall within thirty (30) calendar days from the postmark date or the electronic delivery date of the insurer's written notice dispute the amount of the overpayment by submitting additional information to the insurer.

(3) If a provider files a dispute in accordance with subsection (2) of this section, no recoupment shall be made until the dispute is resolved. If a provider does not dispute the amount of the overpayment and does not provide a refund as required in subsection (2) of this section, the insurer may recoup the amount due from future payments.

(4) All disputes submitted by providers pursuant to subsection (2) of this section
shall be processed in accordance and completed within thirty (30) days with the insurer's provider appeals process.

304.17A-714 Collection of claim overpayments -- Dispute resolution.

(5) An insurer may recover an overpayment resulting from an error in the payment rate or method by requesting a refund from the provider or making a recoupment of the overpayment from the provider, subject to the provisions of subsection (6) of this section. A provider may dispute such recoupment in accordance with the provisions contained in KRS 304.17A-708.

(6) If an insurer chooses to collect an overpayment made to a provider through a recoupment against future provider payments, the insurer shall, within twenty-four (24) months from the date that the insurer paid the claim, and at the actual time of recoupment give the provider written or electronic documentation that specifies:

(a) The amount of the recoupment;

(b) The covered person's name to whom the recoupment applies;

(c) Patient identification number; and

(d) Date of service.

Effective July 15, 2002

KRS 304.17A-730 Interest

If the MCO fails to pay an original or corrected clean claim within thirty (30) calendar days after the acknowledgement of receipt of the clean claim, interest shall be paid.

- Paid within 1 to 30 days—12% per annum
- Paid after 31 to 60 days—18% per annum
- Paid after 61 days—21% per annum

Reasons for filing a complaint

- Did the MCO fail to pay, deny or contest the **clean claim** within thirty (30) days of the submission of the clean claim as required in KRS 304.17A-702?
- Did the MCO fail to acknowledge the **receipt of a claim** within the time frame as required or fail to notify you at the time of acknowledgement of **receipt of the claim** of any errors or missing information in the billing instrument as required in KRS 304.17A-704?
- Did the MCO fail to follow the procedures for claim overpayments, recoupments and/or dispute resolutions as required in KRS 304.17A-714?
- Did the MCO fail to pay interest as applicable in accordance with KRS 304.17A-730?
- Did the MCO discriminate against a provider who is located in a geographic coverage area and who is willing to meet the terms and conditions for participation established by the MCO and DMS as prescribed in KRS 304.17A-270?
- Did the MCO fail to follow the insurance statutes found in KRS 304.17A-700 thru 730?

MPPC Complaint Form

A sample complaint form with instructions is included in the information which was available to you when you checked in for this session. If you don't have one, they are available at the check in desk. Please pick one up on the break after this presentation.

What is the complaint process?

More details in the packet of information which was available upon check in

- Every complaint must be submitted in writing using the MPPC Complaint Form
- Complaints are filed per Medicaid Member
- Complaint received by MPPC
- MCO is given 15 calendar days to respond
- MPPC receives & reviews response from MCO to determine next course of action

Checklist

- ✓ Completed complaint form per Medicaid member
- ✓ Copy of all billing instruments
  - ✓ CMS 1500—UB 04—ADA Dental
- ✓ Identify billing instruments as to original or corrected
- ✓ Copy of all supporting documentation
- ✓ Place information in chronological order as applicable to disputed claims

Complaints

In the beginning:

- Credentialing issues
- Prior Authorizations
- Coding issues
- Non-participating providers
- Denials of claims
- Recoupments
- Retro-eligibility of Medicaid members
- CPT code changes effecting rates

Trending now:

- Behavioral Health
- Provider info not matching DMS records
- Recoupments
- Retro-eligibility
- CPT code changes
- Prior Authorizations
- Credentialing
- Coding issues
- Contractual rates

Why are we so particular?

- Collects the necessary information for the MCO to review and respond to the complaint
  - MPPC to resolve
- Streamlines and standardizes the complaint process
- Allows for MPPC Branch to collect data to help identify trends and issues
- Results have proven to be effective

Prompt Pay (DOI--MPPC)

- DMS transferred complaints to DOI on April 15, 2013
  - Transferred 188 complaints----23,531 claim lines
  - Resolved 185 complaints---23,268 claim lines
  - Recovered $285,782 --- $31,733 interest
- DOI/MPPC: April 15, 2013 thru June 30, 2014
  - Received 4,346 complaints-----19,259 claim lines
  - Resolved 2,742 complaints---14,833 claim lines
  - Recovered $1,218,661 --- $87,549 interest

What has been done ?

Dept. for Medicaid Services
November 1, 2011 thru April 14, 2013
Received:

243 complaints
22,881 claim lines
Resolved:
49 complaints
5,031 claim lines
$93,141 recovered
$1,613 interest

Department of Insurance
April 15, 2013 thru June 30, 2014
Transferred from DMS to DOI

188 complaints—Resolved 185
23,531 claim lines—Resolved 23,268
$285,782 Recovered
$31,733 interest
Received:
4,346 Complaints
19,259 Disputed Claim lines
Resolved:
2,742 Complaints
14,833 Disputed Claim lines
$1,218,661 Recovered
$87,549 Interest
Totals: 2,927 compl.—38,101 lines
RECOVERED: $1,504,443--$119,282
TOTAL----$1,623,725

What has been done thru June 30, 2014?
DMS & DOI Combined Efforts

2,976 Complaints resolved

47,558 Claim lines resolved

$1, 597,584 RECOVERED

$120,895 INTEREST PAID

TOTAL RECOVERED INCLUDING INTEREST

$1,718,479

Who Moved My Cheese?

- **Change Happens**
- **Anticipate Change**
- **Monitor Change**
- **Adapt To Change Quickly**
- **Change**
- **Enjoy Change**
- **Be Ready To Change Quickly and Enjoy It Again**

- *They Keep Moving The Cheese*
- *Get Ready For The Cheese To Move*
- *Smell The Cheese Often So You Know When It Is Getting Old*
- *The Quicker You Let Go Of Old Cheese, The Sooner You Can Enjoy New Cheese*
- *Move With The Cheese*
- *Savor The Adventure And Enjoy The Taste Of New Cheese*
- *They Keep Moving The Cheese*

THANK YOU

We wish to express our sincere appreciation for the assistance and cooperation of all those who have participated in the facilitation of complaints filed with the Medicaid Prompt Payment Compliance Branch at the Department of Insurance. Our team appreciates you and your efforts, thank you.